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And seven minutes later, at 1:46 a.m., she took out 10 milligrams. And it was not charted.

And I asked how she could take out, in seven minutes, 14 milligrams of morphine on the same patient. She did not have an explanation.

And certainly, that was over the amount that the doctor had ordered on that patient.

THE ARBITRATOR: Let me interrupt for one second. Do we have a patient initials for Scenario 3?

MR. CAHILLANE: Yes. Actually, it is the patient on the other exhibits whose initials are CI.

THE ARBITRATOR: Okay.

MR. CAHILLANE: And I see that we just missed on the redacting of the last name up there.

THE ARBITRATOR: Okay. I wasn't sure if that's the case.

MR. CAHILLANE: I think that's Patient Number 5 on the prior exhibits.

Q. (By Mr. Cahillane) So, at that time, Ms. Brown, did you make a decision as to what to

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do?

A. Yes. Since there was no plausible explanation that I could see for any of this; there was so many cases where medication was taken out, documented it had been given previously; the comments about bolusing through the IV could not be accurate because the IV had been discontinued; there were too many discrepancies at that point, without any explanation.

So, the decision was made to terminate Nancy for failing to adhere to our administration policy, and suspected drug diversion.

Q. At either of these meetings, was there any other explanation given by Nancy Dufault or the union representative concerning these matters that was not recorded in these notes?

A. No.

Q. Or that you have not testified to?

A. No.

Q. Did either Ms. Dufault or the union representative ask for anything else at either meeting?

A. No.

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Q. And I take it that you then procured a disciplinary action form, which is, I believe, Joint Exhibit Number 2?

A. That's correct.

Q. Okay. You might want to look at the other side.

A. Mm-hmm. That's correct.

Q. One other thing, Ms. Brown: Does the hospital have policies regarding medication practice, in terms of giving it to patients?

A. Yes, it does.

Q. I'm just going to show you a copy of a document, and ask you if that is the nursing department policy with respect to medications?

A. Yes, it is.

MR. CAHILLANE: And I would like to introduce that.

THE ARBITRATOR: Let's identify it as Hospital 15.

MR. HICKERNELL: Can I have a moment to review it, please.

Can I have voir dire on this, please?

THE ARBITRATOR: Yes. Is Hospital 15 being offered into evidence at this time?

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MR. CAHILLANE: Oh, I'm sorry. I thought I had. Yes. I am offering it as evidence.

THE ARBITRATOR: Okay. Voir dire questions.

VOIR DIRE BY MR. HICKERNELL:

Q. Okay. Ms. Brown, is this the policy that was in effect in 2002?

A. Yes.

Q. And has it been revised since?

A. No.

Q. So, it's still in effect?

A. This is still in effect.

Q. There's some references in the document to appendixes and attachments?

A. There's an Appendix C. It looks like it's a chemotherapy order form. I didn't attach that in. It's a written standard order form for chemotherapy.

Q. On the second page, the last bullet point, there's a reference to Attachments 1 and 2. What are those?

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are not a verbatim transcript of the first meeting?
A. No. There was no verbatim transcript of the meeting.
Q. And in fact, a verbatim transcript would be substantially longer than the two pages here?
A. Mm-hmm.
Q. Did you consider, at any time, asking Nancy Dufault to undergo a drug test?
A. No. We didn't ask her -- we didn't ask her.
Q. And did you consider asking her?
A. No. That was not part of the initial consideration. And it did not come up in further conversations, because of the responses that we received in those meetings, which was pretty much stating that she either couldn't recall, or she had bad documentation.
It did not seem to be something that was appropriate to ask at that time, since she was claiming all of this was just poor documentation.
Q. So, fair to say that with regard to

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the issue of substance abuse and SARP, you were asking for Nancy to state that she needed help?
A. We were asking for an explanation for the scenarios that we presented to her around numerous discrepancies between the medication she removed from the machine, and what she documented.
And I was not asking her to step forward to tell me, you know, if she was using the drugs. I simply was asking, in the meetings, for an explanation of the discrepancies.
Q. Right. But you told me a few minutes ago about your meeting with Ms. Ventura.
A. Mm-hmm.
Q. And as I understood it, you discussed the possibility of SARP. And there was an agreement that if she asked for help, you would at least consider putting her on a leave of absence while she underwent the SARP program. Is that correct?
A. Correct.
Q. So then, is it fair to say that with regard to the issue of substance abuse, you were waiting for her to ask for help?

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A. I did give her, I thought, an opportunity. At the end of the -- which I forgot to tell you. You asked that.
At the end of the August 29th meeting, which the HR person was there, myself, Jean, her Union rep, and Nancy, before we concluded the meeting, I did ask her if she would like to have a private conversation with anyone that was present in the room, including HR.
And I was trying to give her an opportunity, that if she had an issue, and wanted to bring that forward, that any one of us would have been available to sit with her.
But at that point, she only remained in the room with Dave Powers, who was the MNA rep.
Q. Did you ever observe in Nancy, or have anyone report to you, an observation of an erratic behavior consistent with drug abuse?
A. No.
Q. Can I direct your attention to Joint Exhibit 1, please.
THE ARBITRATOR: Joint Exhibit 1 is the collective bargaining agreement?

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MR. HICKERNELL: Yes.
Q. (By Mr. Hickernell) And specifically referring to Section 6.09 on page 17.
A. Mm-hmm.
Q. And in your current position, are you generally aware of the terms of the collective bargaining agreement?
A. Yes, I am.
Q. All right. And are you specifically aware of the existence of Section 6.09?
A. Yes, I am.
Q. And was that section in existence in 2002?
A. Yes.
Q. And did you consider invoking that section in dealing with Ms. Dufault?
A. There was not a question of fitness for duty at that time. We were questioning drug diversion.
She did not have anything that made me think, clinically, that she was involved in -- that it was a fitness for duty issue.
Q. Okay. During the August 27th meeting, when you were presenting the cases to Nancy, the

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A. I did come up with one that had multiple -- I had removed multiple vials of Ativan, and thinking, at the time, that it might send a trigger off to pharmacy.

But as I wanted accountability for my med, that I had signed off.

Q. And what did you do next?

A. The weekend went by. And I got a call from Mary Brown on Monday morning at 8:30 in the morning, setting up the meeting for 8/27 at 10:00 o'clock.

Q. And as best you recall, what did she say when she called you?

A. This was my chance to dispute the discrepancy, or give my explanation of the transgressions that they had found between the Omnicell and my SMS documentation.

Q. And what did you say, if anything?

A. I don't think I said anything special. Nothing that I can recall.

Q. What happened next?

A. I went to the meeting the next morning. Mona, the union rep, Jane D'Espinosa was there, Mary Brown, and myself.

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Q. And as best you can recall, will you tell us what happened at the meeting, identifying specific speakers when possible.

A. Mary Brown sat to my left. On my right, immediate right, was Mona, the Union rep. And Jean was on her right.

At the meeting, Mary presented me with Omnicell readouts, which was the first time I had ever seen any of those sheets, and our MARs or SRS readouts of documentation of the medications that were administered to the patients.

THE ARBITRATOR: Had you seen MAR readouts before?

THE WITNESS: Yes, I had. Those are our work sheets that we use on the unit.

THE ARBITRATOR: But the readouts you had seen before?

THE WITNESS: Right.

THE ARBITRATOR: But not the Omnicell readout?

THE WITNESS: Right.

Q. (By Mr. Hickernell) And what happened? Can you describe more specifically what happened as she made that presentation to you?

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A. The meeting lasted between 30 to 40 minutes. She would present -- show me the Omnicell, show me the SMS, and then expect me to recollect what had transpired on this or caused me this discrepancy.

Q. And did the cases that she showed you correspond to the cases set forth by the Hospital in its presentation here?

A. Yes, they did.

Q. And other than the Omnicell and the SMS printout, what documents were you shown?

A. None.

Q. Was there no case in which you were shown any other documents?

A. No, there was not. Not at the first meeting.

Q. And were you able, on the 27th, to recall the specific instances that were presented to you?

A. I tried to give responses to what could have happened, or what could have caused this discrepancy on them.

But not knowing who the patients were,

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or even being able to associate, even if they gave me a name, what the patient was -- I mean, most of the events were two months prior.

Q. So, were you able to recall the specific instances?

A. Example: The Ativan that they questioned me about, the 320 milligrams, I said I must have mixed -- I had removed from the Omnicell 320 milligrams at 6:34, thereabouts, according to the Omnicell readout.

I said, "I must have mixed two drips at 160 concentration, that I would have failed to sign one drip out, depending on when the time was calculated, what the drip was," which Jean informed me was 25 ccs an hour.

So that, it would be, for my 12-hour shift, I would need 300 milligrams. And I had taken 320 out.

Q. And as you made those statements at the meeting, did you have a specific recollection of what had happened?

A. Not really. Not even of the Ativan. I would just surmise that that is what I did with the -- took out the 320, and mixed two drips, one

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being for when I would need it, whatever time on my shift.

Because hopefully, this drip which was already infusing, going at 25 an hour, whatever time the previous nurse to me would have hung it, depending on when I would have signed it out, or would need it in the SRS, and then leave a courtesy, or enough medication, so they don't immediately, upon assumption of the patient care, have to mix a bag.

Q. And was anybody taking notes at that meeting?

A. Jean D'Espinosa.

Q. Anybody else?

A. Not that I can recall. Oh, and Mona was, the Union --

Q. I'm going to show you what's been marked as Hospital Exhibit Number 14. And specifically, the first two pages.

Drawing your attention to Case 1, there's a quotation attributed to you there. Did you say that?

THE ARBITRATOR: Read it into the record, just so it's clearer.

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Q. (By Mr. Hickernell) The quotation attributed to Nancy says, "I gave the drug -- just didn't chart it," unquote.

A. I cannot recall if I said those words specifically. I know that I asked Jean if it was not documented in the nurse's flow sheet that the drip was going at 25 an hour.

And her response to me was that, "If it's not charted, it's not documented," that, "The nurse's notes is not a legal part of the chart."

Q. Drawing your attention to Case Number 2, there's a quotation attributed to you. Quote, "Equal to the dose ordered," unquote. Did you make that statement?

A. I could have.

Q. And in the second part of Case 2, there's a quote attributed to you. Quote, "Have no answer for that," unquote. Did you make that statement?

A. They expected me to recall patients, that in administering this medication to this patient, I could not lie and say that I remembered medicating Shelly's patient for her.

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So, I may have said, "I have no answer for this."

Q. On the second page, in Case 3, there's a quotation attributed to you. "I guess I didn't chart it .... Bad documentation on my part," unquote. Did you say that?

A. On this instance, I asked Jean if there was nothing charted around the nurse's notes around the time x-ray comes through. She said there was not.

It is not my practice with an orientee to document, unless something is transgressing, or I need to intervene.

So, I can't imagine that I said, "Bad documentation on my part," because I would have expected Tawnia to be doing the documentation.

Q. And you referred to your practice. What was your practice with regard to documenting while you were precepting another nurse?

A. Unless I had to intervene to do something, say a doctor was giving the nurse a hard time, or the patient was overcomplicating the orientee, as a preceptor, I did not step in. I allowed them to be able to manage their time and their skills.

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Q. Drawing your attention to Case Number 4, there's a quotation attributed to you. "I bolused through the IV drip ... Used 999 to bolus at 8:12 and 4:30 ... Then used the 18 milligrams to replace the IV," unquote. Did you say that?

A. What I said was something similar to that. This was the only account, in the time that they had placed me on administrative leave, of my being able to recall anything that might be alarming to the pharmacy, which is what Jean said had -- something had triggered the pharmacy's readouts.

And I said that I did recall this instance and what I had done with the medication. Mary Brown is the one who told me how much medication I had removed from the Omnicell.

I did say that I bolused through the drip, hanging drip. I do not recall saying that the drip was running.

However, I did not go any further, when I thought about what I had done, because of my practice issues regarding adding medication to an existing IV drip.

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came from specific medical records, correct?
A. The Omnicell readouts and the SMS that she showed me. Yes.
Q. And during and after that meeting, you did not ask for copies of those records or of any further records from those patients, did you?
A. No, I did not.
Q. All right. And at the first meeting, you had a union representative there with you?
A. Yes, I did.
Q. Did the union representative ask for copies of those medical records?
A. I do not believe she did.
Q. And at the second meeting, you again had a union representative there, present with you, did you not?
A. I did.
Q. And neither you nor the Union representative, at or after the second meeting, asked for copies of the medical records that were being shown to you?
A. We did not.
Q. And that's because you already knew that what was going on here was that you had

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overmedicated the patients?
A. I've never heard of a nurse being fired because they made a med error, in my 25 years at Mercy.
Q. Well, what if the overmedication was because the nurse didn't agree with the doctor's order, and thought the patient was agitated or disturbed and needed more? Would that be grounds for termination, do you believe?
MR. HICKERNELL: Objection. Foundation. How is she in a position to administer discipline?
MR. CAHILLANE: I'm asking her opinion of whether or not it would be grounds for termination if a nurse decided to administer more medication to the patient than had been ordered by the doctor.
THE ARBITRATOR: Is the Hospital now saying that this Grievant was terminated for suspected overmedication?
MR. CAHILLANE: No. What happened, I thought that the Grievant freely admitted in her direct testimony, was that the explanation for the missing narcotics is that she gave too much

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to the patient.
THE ARBITRATOR: Listen to the questions carefully.
Q. (By Mr. Cahillane) Well, would you agree that if a nurse decided to give more medication, particularly a narcotic, to a patient than was prescribed by the doctor, that that could be grounds for termination?
A. Again, I have never heard of this. And I can't imagine a nurse doing that.
Q. Now, if we could just go to the case of the patient PR, which is on Hospital Exhibit Number 5.
MR. CAHILLANE: And am I correct, Mark, Union Exhibit 5?
MR. HICKERNELL: I'll have to check. I think PR may be in Union Exhibits 5 and 6. Would you like the witness to be given both of those?
MR. CAHILLANE: Well, she might want them in front of her.
Q. (By Mr. Cahillane) On August 27th, you were presented with some information by Mary Brown concerning this patient and what had

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occurred between June 19th and June 21st, correct?
A. Information being the Omnicell readout and the SMS readout.
Q. And did you not testify that you yourself, at the time, in August, questioned your own practice with respect to the time when you state that you bolused the medication into the patient?
A. I questioned my practice of administering or adding to the bag medication, yes.
Q. And you said, in fact, that it was not a common practice?
A. Absolutely.
Q. And in fact, it's not a proper practice, is it?
A. No. As I had never done it before, I would say no.
THE ARBITRATOR: Do we have a definition of bolusing in the Hospital records, so that we all know what bolusing is? What's the definition?
Q. (By Mr. Cahillane) As you understand

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of the termination, correct?
A. Correct.
Q. And that used the term suspicion of diversion of controlled substances, correct?
A. Question of.
Q. Question of. And at that point, or shortly thereafter, you and/or the Union, on your behalf, filed a grievance concerning your termination, correct?
A. I believe that's proper practice.
Q. Well, that's what happened, correct?
MR. HICKERNELL: Just answer the question.
Q. (By Mr. Cahillane) You filed a grievance?
A. I told David to file a grievance. Yes.
Q. And in the grievance procedure, when you were terminated, you first had a chance to have your grievance heard internally, at the Hospital, by, I believe it's the Hospital president, or his designee, correct?
A. Because this was a termination, I understand it goes straight to Step 3? Is that

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what you're asking?
Q. Yes.
A. Correct.
Q. Okay. But at that point, you have the opportunity, do you not, together with the Union, to present your case for why you should not have been fired?
THE ARBITRATOR: At the Step 3 hearing?
MR. CAHILLANE: Yes.
THE WITNESS: I would not know what the protocol is. But if you're telling me that's it, yes. If that's the Union, yes. Correct.
Q. (By Mr. Cahillane) Well, let me ask you this: Did you understand that the grievance proceedings provided you with an opportunity to make your claim that the Hospital had violated the contract by terminating you?
A. Correct.
Q. Did you go to the Step 3 hearing?
A. Yes, I did.
Q. And when you went to the Step 3 hearing, did you indicate, in any way, that, "This is just a matter of my having made a

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medication error"?
A. No, we did not.
THE ARBITRATOR: Now, medication error? Is that what you meant?
MR. CAHILLANE: Yes.
THE ARBITRATOR: As opposed to documentation error?
MR. CAHILLANE: Yes.
THE ARBITRATOR: Okay. Keep me on board. Those are two different things.
Q. (By Mr. Cahillane) Well, you understood, at this point, by the time of the Step 3 grievance, you understood that you had not been fired just for a documentation error?
A. That they were accusing me of diversion of controlled substance, either using, or in some way inaccountability for medication that I had withdrawn from the Omnicell. Correct.
Q. Okay. So, you understood that. But you didn't indicate, at the Step 3 hearing, that, "There's no just cause for my termination, because this, in fact, was just a medication error on my part," or errors?
THE ARBITRATOR: Wait, wait, wait.

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Now are you misspeaking yourself.
MR. CAHILLANE: No. That's exactly what I mean.
THE ARBITRATOR: Okay. Medication error. The question is -- state the question again.
Q. (By Mr. Cahillane) Well, do I understand that here, in these proceedings, Miss Dufault, it's your contention that whatever discrepancies exist in the record as to the amount of drugs withdrawn, versus the amount of drugs given the patient are explainable by inadvertent medication errors on your part?
THE ARBITRATOR: What is a medication error, by your definition?
MR. CAHILLANE: Giving a patient too much or too little of the drug that was prescribed to them. Or not giving it at all. Or giving a medication that had not been prescribed.
THE ARBITRATOR: That's a lot of different kinds of medication errors.
Q. (By Mr. Cahillane) Well, in this case, let me amend my question to be: Is it your contention, here and now, that whatever

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is the responsibility of the nurse to document all meds/IVs given prior to leaving the hospital, and when the next shift's MAS are printed. RNs on the night shift will check all physician's orders written," I take it it is during, "the past 24 hours, and the medication administration schedule to assure accuracy."

Q. (By Mr. Cahillane) Do you see that paragraph, Miss Dufault?

A. Yes, I do.

Q. Now, the MAS is, is it not, a medical administration sheet?

THE ARBITRATOR: Is that synonymous with the SMS.

MR. CAHILLANE: I'm going to ask that question next.

THE WITNESS: That's the med sheet that we get, the MAS.

Q. (By Mr. Cahillane) Right. And is the MAS, the med sheet, is it like this document here?

A. Yes, it is.

Q. One of the --

A. Well, what we've been calling the SMS,

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which is the equivalent with the MAR?

Q. Yes.

MR. HICKERNELL: Can you tell us what document you just showed her, for the record.

MR. CAHILLANE: Well, this one happens to be -- I didn't write that exhibit on it. But it regards patient B. I believe this one is -- well, it's the July 17th incident. This must be patient BB. It's page 2.

But what I'm showing is a medical administration sheet, that I believe there is one contained in the records that we have in both exhibits for every single patient.

THE ARBITRATOR: Except that there, it's called the MAR, instead of the MAS.

MR. CAHILLANE: Correct. I just want to ask her about that.

THE ARBITRATOR: Okay.

Q. (By Mr. Cahillane) Those medical administration sheets, Miss Dufault, are the computer's record of the medicine that's been administered to that patient, correct?

A. Correct.

Q. And they are part of the MAR, or the

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SMS computer record, correct?

A. The SMSs that you show us, we have a work sheet that we work off, that that gets discarded.

Q. Well, this document, which is labeled the, "Medical Administration Record," this is what the policy here is referring to, the same thing as what the policy here is referring to as MAS, correct?

MR. HICKERNELL: And can the record just reflect that Mr. Cahillane is holding up Union Exhibit 21, page 2.

Q. (By Mr. Cahillane) Let me ask you this, Miss Dufault: Is it not the case that each day, there is a medical administration sheet printed off the computer?

A. That goes into the permanent record?

Q. Well, is one printed off?

A. One that we write on and discard, that the secretaries run off at the beginning of the shift.

Q. And that is printed off of the computerized record, correct?

A. Correct.

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Q. Okay. So, the information concerning medication administration that is inputted by you or other nurses into the computer is printed out on a daily basis?

A. Correct.

Q. And it's there for the nurses' and the doctors' use?

A. If they needed it. I don't ever recall a nurse going back into the permanent record to see. But I guess, yes. Correct.

Q. That's the permanent record. I'm talking now about the medical administration sheet that's printed each day.

A. You throw that out at the end of each shift.

Q. Okay. But it's printed up for a reason, isn't it?

A. For you to work off for whatever shift you're there. And then it's discarded.

Q. Okay. So, every day, with respect to the patient, you're printing, out of the computerized record, the record that the computer has of the medicine that's been administered to that patient, correct?

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as far -- what did that consist of at Mercy Hospital?
A. Going way back, it was usually a --
Q. Well, let me just say, the last year that you were in active practice.
A. At Mercy --
MS. BUTLER: Are we going back now to 2000? Just to keep me oriented in time.
MR. CAHILLANE: Well, why don't I -- I don't want to go through 30 years.
A. I could summarize if you'd like.
Q. (By Mr. Cahillane) Are you familiar with what would have been -- what was being done at the hospital with respect to documentation of controlled substances in 2002?
A. I believe so, sir, yes.
Q. Okay. And what record would the physician have had to look at with respect to the administration of a controlled substance in 2002?
A. Basically, there were two sources that I would usually turn to.
And if I can modify, briefly, my previous testimony: My active practice terminated July 2001. I hoped to return -- and

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actually provided care for a couple weeks in August of 2001, after the first of two back operations that year. The second occurred on 9/11/2001, that famous day. And I did subsequently operate in 2002 on two physicians' wives, in the process of hoping to return to active practice. And I think it was in the process of doing those procedures that it became obviously apparent that I was not going to be able to sustain the levels of practice to have an active surgical practice that would produce enough to cover the expenses and the income.
To continue back to the question that you addressed, there were two sources that I would generally turn to. The SMS system is a computer system for recording administered medications. And I believe the record is called the MAR, or the medicine administration record. That was a printed out every 24 hours and would be put in the patient's record. So that if I wanted to know what the patient received prior -- or somewhere up to the time of that being printed out, I would go to that. And that would give me a summation of what the patient received and

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when. Be it antibiotic, pain medication, blood pressure supportive medication, every medication would be there.
If I needed something within the preceding several hours, I would then, basically, access the MAR, where this was on computer and had not yet been printed out. Many times, I would either go to -- I would -- I would many times talk with the nurse or go to that record.
But that record was what I expected to tell me, as the responsible physician, what happened from the day that patient came in to the moment that I looked at her.
Q. And would --
MS. BUTLER: And there was a second record, you said.
THE WITNESS: I'm sorry?
MS. BUTLER: You said the doctor looks at two sources.
THE WITNESS: Well, it's the same record, but because it's printed out every 24 hours, in the chart there is an actual printout. On the computer system -- from the time that was printed out until the

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time the next printout occurs is on the actual computer SMS system.
MS. BUTLER: Okay. So the second source would be, if you didn't find out or you weren't fully satisfied, you would go to the computer itself.
THE WITNESS: Yes.
MS. BUTLER: That was what you meant by second source.
THE WITNESS: Yes.
MS. BUTLER: Okay.
THE WITNESS: And that would cover from the time the patient was admitted to the very moment that I was looking at the patient.
Q. (By Mr. Cahillane) And would a -- would it be fair to say that a physician might well be relying on that record, or records, in making decisions as to patient care?
A. Absolutely.
Q. And would that be important with respect to the administration of controlled substances?
A. Yes, it is.

(Robert J. Kasper, M.D., stepped down from the witness stand.)

MR. CAHILLANE: I should get my next witness.

MS. BUTLER: Yes, please.

MR. HICKERNELL: In the meantime, can we enter this as a union exhibit?

MS. BUTLER: Okay. What would it be? Where are we up to now? I see a Union 21. That may be the last one.

MR. HICKERNELL: I think that's the last one.

(Union Exhibit 22, Pharmacy Department Medication Events and Adverse Drug Reactions Policy, admitted)

MS. BUTLER: Let the record show Union Exhibit 22 is admitted without objection.

(Pause in proceedings)

(Patricia Duclos-Miller, R.N., approached the witness stand.)

MS. BUTLER: Please stand and rise your right hand.

Do you swear, or affirm, the testimony you're about to give in this arbitration hearing will be the truth, the whole truth, and nothing but the truth, so help you God?

MS. DUCLOS-MILLER: I do.

MS. BUTLER: Thanks.

PATRICIA DUCLOS-MILLER, R.N., Witness, having been duly sworn, testifies and states as follows:

DIRECT EXAMINATION BY MR. CAHILLANE:

Q. Could you state your name, please?
A. Patricia Duclos-Miller.
Q. And what is your address?
A. 15 Maplewood Road in Farmington, Connecticut.
Q. And what is your present employment position?
A. Director of quality improvement for the Sisters of Providence Health System.
Q. And could you just -- if you could, briefly describe your education and what degrees you hold.
A. Graduate of St. Anselm College, with a baccalaureate degree in nursing. Boston University with a master's. And I'm certified in nursing administration by the Academy.
Q. And have you been a practicing registered nurse?
A. For over 30 years.
Q. Okay. And what positions have you held?
A. I've been director of organizational systems, director of specialty services, nurse manager, staff nurse, former assistant professor at various collegiate programs in the state of Connecticut, and director of nursing.
Q. And when were you first employed by the Sisters of Providence Health System?
A. December 2001.
Q. And just so I'm sure that it's ever been on the record, but Mercy Hospital is part of the Sisters --
A. Correct.
Q. -- of Providence Health System?

And what are your job duties at Mercy Hospital, or Sisters of Providence Health System?

A. To provide resources, in collaboration with quality improvement projects, data management. I've lectured, worked with and facilitated root cause analysis, intensive investigations. I work with physicians on peer review committees and facilitate all of the quality improvement councils.
Q. And have your duties included holding in-service projects regarding proper practice?
A. Yes.
Q. Including proper practice for registered nurses and LPNs?
A. Yes.
Q. And are you, from your position here, familiar with the standards at Mercy Hospital with respect to the administration of

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and documentation of controlled substances?
A. Yes.
Q. With respect to the administration of medication by a registered nurse, are you familiar with something called the Five Rights?
A. Yes.
Q. And what are they?
A. Right patient, right dose, right medication, right route, right time.
Q. And is this a standard which all nurses -- all registered nurses have to follow?
A. All nurses. All licensed nurses, including licensed practical nurses.
Q. Now, and I take it that those standards apply for any narcotic or other dangerous drug?
A. That's correct. It's a fundamentals of nursing, in one of your first nursing courses.
Q. Now, with respect to the administration of a controlled substance by a registered nurse at Mercy Hospital, are you familiar with where the registered nurse who administers a controlled substance is supposed to document that?

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A. Yes.
Q. And where is that?
A. In the computer, in what's called the MAR module of the computer.
Q. And is that also referred to as the SMS?
A. Well, that's the -- the SMS is the computer vendor that we currently utilize. The MAR is a module within that computer.
MS. BUTLER: But they're sometimes used synonymously.
THE WITNESS: Yes.
Q. (By Mr. Cahillane) And is that system at Mercy Hospital, is it relied upon by physicians and nurses, in order to determine what medications a patient has or has not received?
A. That's correct.
Q. Would it be inappropriate practice -- well, is there also on the floor a written medical record that nurses sometimes make?
A. Documentation in the progress notes?
Q. Yes.
A. Sometimes a nurse will document in the progress notes.

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Q. Would it be an appropriate practice for a nurse administering a controlled substance to document it in the nursing notes, but not in the MAR?
A. No, that is not the correct method.
Q. Would it be appropriate for a nurse, in documenting the administration of a controlled substance, to not put the amount of the dosage given to the patient?
A. That is an improper method of documentation.
Q. Would it be a proper -- proper for the nurse to not put the correct time at which the controlled substance was administered?
A. That is an improper way to document.
Q. Would it be acceptable for the nurse to sometimes document the administration of a controlled substance in the nursing notes, but not in the MAR?
A. No, that is unacceptable. It is not the policy or the standard.
Q. Would it be an acceptable practice for a nurse to -- in administering a controlled substance, to take out additional medication ahead of time, in anticipation that there might be in the future an increase in the dosage for the patient?

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A. No. That is improper.
Q. If a patient were receiving a controlled substance by means of a drip, an IV drip, and the physician ordered the drip discontinued, would it be appropriate for the nurse to later -- who later has an order for an IV push for a dose of that drug, to use the discontinued drip?
A. No. That is an incorrect and improper method.
Q. And would it be fair to say that a registered nurse would be obligated to follow the physician's order with respect to that drip?
A. That is correct. The physician's order said "IV push."
Q. Would it be appropriate for a nurse to have a different standard of documentation with respect to the administration of a controlled substance for a patient who was a DNR?
A. No. There should be no difference

TZ

in standard.
Q. Are you familiar with there being such a practice or standard at Mercy Hospital?
A. No.
MR. CAHILLANE: That's all.
MS. BUTLER: You have to answer for the record. Your answer was?
THE WITNESS: No.
MS. BUTLER: Okay.
Your witness, Mr. Hickernell.
MR. HICKERNELL: Just have a two-minute break?
MS. BUTLER: Two-minute break.
(Pause in proceedings)
MR. CAHILLANE: I do have one other question that I forgot to ask, if I may.
MS. BUTLER: Okay. Back on the record. An afterthought type question.
Q. (By Mr. Cahillane) Ms. Duclos, if a registered nurse has, for whatever reason, withdrawn more narcotic than what is prescribed and in fact only gives what is prescribed, what is the standard of practice as to what she does with the additional narcotic?

A. The additional narcotic --
Q. Or controlled substance.
A. -- controlled substance needs to be wasted, and that needs to be countersigned by another registered nurse.
MR. CAHILLANE: That's all.
MR. HICKERNELL: All set for cross?
MS. BUTLER: Okay. Yes, go ahead.

CROSS-EXAMINATION BY MR. HICKERNELL:

Q. Good morning.
Where is your current place of work?
A. Here. My office is here, but I work for the Sisters of Providence Health System, of which Mercy Medical Center is part of that system.
Q. And, as a director of quality improvement for the system, are you responsible for other hospitals as well?
A. Providence, which is considered part of Mercy Medical Center. I'm a resource to the long-term care facilities, which are part of the health system, and the home care agency,

Community Home Care, Incorporated.
Q. Are you here every day of the week, or are you --
A. Yes, I am. Unless I go out to meetings off-site.
Q. And how often do you do that?
A. Probably twice a month, over to Providence.
Q. And you sort of went through, briefly, your resume as a practicing registered nurse. Where did you work as a staff nurse?
A. Newton Wellesley Hospital, in Massachusetts. New Britain General in New Britain, Connecticut. Bristol Hospital in Bristol, Connecticut. And John Dempsey Hospital in Farmington, Connecticut.
Q. And when you were a nurse manager, where did you practice?
A. Bristol Hospital.
MR. HICKERNELL: That's all the questions I have. Thank you.
MR. CAHILLANE: Just with respect to her background, I do have one question.
MS. BUTLER: Mm-hmm.

REDIRECT EXAMINATION BY MR. CAHILLANE:

Q. Do you hold any leadership positions in nursing?
A. Yes, I do. I'm currently the president of the Connecticut Nurses Association.
MR. CAHILLANE: Okay.
MS. BUTLER: The equivalent of the Massachusetts Nursing Association?
THE WITNESS: No. The Massachusetts Nursing Association --
MS. BUTLER: Which is a union.
THE WITNESS: That's right. They --
MS. BUTLER: So that's why I was wondering.
THE WITNESS: They separated from the American Nurses Organization, which is the national organization. Each of the states belong to the national organization, but Massachusetts and California no longer belong to the American Nurses Association.
MS. BUTLER: Okay. I guess what I was confused about was whether the organization that you're president of is

IV

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bottle except where your IV tubing goes in. So she would have had to disconnect, keep this -- focus on keeping this totally sterile, which is hard. Alcohol your top of the bottle anytime you're going to reconnect or add something. Excuse me. With the needle. Take alcohol to clean it.

Put your needle in and deliver it. Let the medicine go in, in this case the 18 cc's of volume. She had 18 milligrams of the drug. Let it all go in there. Disconnect.

Which I'll just insert -- say, at this point, that we try to get out of using needles here whenever possible. And, in this case, by doing it this way, you would have to use the needle. And it's just general nursing practice nowadays, you try to avoid using needles, at whatever cost, because of sticks. So you cap off the needle so no one else sticks themselves.

So you added the medication. Then you would have to take this spike, which is the end of the -- one -- the other end of your IV tubing, and reinsert it into the bottle. And

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that just is a basic principle of nursing, that you don't ever want to spike and respike, for infection control purposes.

And then hang the bottle up and leave it there. And it's unused, so I'm baffled by why you added medication when you were -- according to Nancy's testimony, there was already enough in there. But -- so she added the medication, and it just stayed there, unused.

Q. Well, let me ask you. I mean, in terms of -- at least from -- from the record and from the prescription that was given, is there any apparent purpose for adding 18 milligrams to that bottle?

A. No apparent purpose because the order was already DC'd, so it shouldn't have been used in the first place. Plus, if she did administer the controlled -- the Ativan in this method, she documented in the computer already that she gave it at 8:00 and at 12:00. So as far as her accountability, her record of administration, it was already there. So there is no -- in my mind, any purpose why she would take it out and then add it to something that's

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not even being used.

Q. Okay. I think that's all with respect to the IV.

With respect to documentation, when the nurse has administered Ativan or morphine or any controlled substance, she's supposed to document it where?

A. I'm sorry, can you repeat the question.

Q. When the nurse has administered any controlled substance, she's supposed to document it where?

A. In the computer, in the medication administration record.

Q. Okay. And with respect to that computerized record, is there any part of that record that the nurses, and possibly physicians, would be relying on during their shift, in order to see what the patient has or should get?

A. Yes. There's, actually, two pieces. As Dr. Kasper pointed out, there is the medication administration record, which gets printed out during the night shift. And that is everything that's received, for example,

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yesterday. It gets printed out last night, in the middle of the night. The secretary or nurse will file it in the chart. So physicians and nurses can look at that medication administration record to see everything the patient received yesterday.

Now, as far as for today, there's two ways that a nurse will look up what's happening today. One, they can use that medication administration schedule. And that's, actually, kind of our -- the nurse coming on, that's their bible of what meds the patient is doing. And I shouldn't use the word "bible." Their schedule of drugs: When the patient -- what the patient is on and when they're due. And also on that med administration schedule is what the patient most recently received, by the previous shift.

MS. BUTLER: So the med administration schedule --

THE WITNESS: Yes.

MS. BUTLER: -- is synonymous with what we've sometimes called the flowchart? Or not.

THE WITNESS: No. We have the bedside flowchart, which in the ICU we use to document all our active, current vital signs, etc. Our assessment findings. So that's a bedside chart. And I know that confused you in the past. No, it's not always kept at the bedside. It's kept on a clipboard. So sometimes it's at the nurses' station, but many times the nurse carries that yellow flowsheet into the room to document things. Okay.

MS. BUTLER: Now, there's -- medication administration schedule is what? And what does that look like?

Q. (By Mr. Cahillane) Well, did you procure an example of one of these?

A. Yes. I took one -- printed one out.

Q. I'd ask if you can identify that as --

A. Yes. This is a medication --

Q. -- as an example of --

A. -- administration schedule.

Q. And --

MS. BUTLER: Well, I'm --

MR. CAHILLANE: Yes, I'd like to enter that as a hospital exhibit.

MS. BUTLER: Hospital 17, perhaps?

MR. CAHILLANE: Yes, I believe that would be it.

MS. BUTLER: Okay. We're identifying this exhibit as Hospital No. 17. And this is something called the medication administration schedule. Shall we call it the MAS?

THE WITNESS: Yes.

(Hospital Exhibit 17, medication administration schedule, marked for identification)

Q. (By Mr. Cahillane) And is that, in fact, what it's referred to as, the MAS?

A. Yes. Nurses usually call it their med sheet.

Q. And this med sheet is printed out from the computer.

A. That is printed out from the computer -- usually by the secretary, if there's

a secretary, or the nurse will have to print it out -- within the first hour of their shift. So, for example, I'm working days today at 7 a.m. Between 7:00 and 8:00 myself or the secretary will print out my med sheet, my medication administration schedule, for me for my shift. So I will know everything the patient is due. Like on page 1 of that it shows all the drugs, the dosages, when it was started. And, also, in this example, where it says date, June 12th, it shows the times that the patient is due for them. So, in this case, these are routine orders, scheduled drugs. And page 2 also has some more scheduled drugs.

Page 3 has the PRN order. And, in this case, many of the examples we are referring to are PRN orders.

Q. And I take it that the accuracy of the information on this MAS is dependent upon the accuracy of the information that has been put into the MAR computer.

A. One hundred -- totally. Right.

MS. BUTLER: Remind me again what "PRN" stands for.

THE WITNESS: "PRN" stands for medications that are ordered by the doc that are given by the nurse only when the patient needs them, according to certain parameters.

MS. BUTLER: "Per required" --

THE WITNESS: Or "per RN," I've always assumed. I'm not really sure. A lot of these are Italian terms. The nurse makes the -- Italian, sorry. Latin.

MS. BUTLER: PRN -- well, just so it can stick in my unmedical mind, per patient request?

THE WITNESS: Sometimes it's request. Sometimes it's a need that the nurse determines. For example, a medication like -- we'll use this page. Page 3, the second one down, is the lorazepam, the Ativan. Or if we look at the third one down, Ativan. It's .5 milligrams P.O., by mouth, every four hours PRN. And it says down at the bottom there, "for anxiety." So, in other words, if someone is not anxious, we're going not

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Hoop #14

Tuesday, August 20, 2002
Nancy Dufault placed on administrative leave pending investigation of narcotic discrepancies.

Tuesday, August 27, 2002 10:00 a.m.
Meeting – Mary Brown, Director of Med/Surg Nursing, Jean D'Espinosa, RN, Nurse Manager, Nancy Dufault, RN, ICU, Mona Karkut, RN, OR, MNA Representative

Mary Brown explained the purpose of the meeting. Review discrepancies between omnicell controlled substance report and medical record documentation. Meeting to give Nancy Dufault an opportunity to explain findings.

Report used: Omnicell Transaction by User
User Name: Nancy Dufault. Date range of report 4/1/02 12 a.m. through 8/21/02 12 Noon.
Five (5) cases were presented to Nancy Dufault.

1. Omnicell Report
   6/19/02 6:28 p.m. 2 each Lorazepam 20 mg/10ml R
   6/19/02 6:28 p.m. 10 each Lorazepam 20 mg/10ml R
   6/19/02 6:28 p.m. 4 each Lorazepam 20 mg/10ml R
   Total of 320 mg of Lorazepam withdrawn by Nancy Dufault,
   ICU Flowsheet 6/19/02 to 6/21/02 – R shows patient receiving 25 mg/hr – documented by Nancy Dufault.
   IV administration record 6/19/02, 6/20/02 – no documentation of IV ativan.
   Issues: Lack of documentation in patient's medication record.
   Mixing of additional IV solutions in advance – question of controlled substance
   Loss of revenue due to pharmacy charges from medication record.
   Explanation by Nancy Dufault: "I gave the drug – just didn't chart it"

2. Omnicell Report
   7/15/02 11:51 p.m. 1 each Lorazepam 2mg B
   7/16/02 12:19 a.m. 1 each Morphine Sulfate 4 mg B
   withdrawn by Nancy Dufault
   7/15/02 10:01 p.m. 1 each Lorazepam 2 mg B
   7/16/02 12:52 a.m. 2 each Lorazepam 2 mg B
   withdrawn by Tawnia Iwasinski

   Issue: Tawnia was on orientation working with Nancy Dufault (preceptor). Tawnia documented the medications she had removed from the omnicell. No documentation of medications withdrawn by Nancy.
   Response: Nancy stated, medications were given; it was "equal to the dose ordered." Nancy thought the orientee would chart.

   Omnicell Report
   7/17/02 7:42 p.m. 1 each Lorazepam 2 mg B
   withdrawn by Nancy Dufault.
   7/17/02 8:12 p.m. 2 each Lorazepam 2 mg B
   7/17/02 8:34 p.m. 1 each Morphine 4 mg B
   withdrawn by Michelle Lund (assigned to the patient)
   IV administration record shows medications withdrawn by Michelle Lund are charted.
   Medication withdrawn by Nancy Dufault is not charted in the record or on the flowsheet.
Issue: was the medication administered? If it was administered – physician order was for Lorazepam 2 – 4 mg q 2 hours prn - patient would have received 6 mg within 30 minutes.
Response: Nancy stated, "have no answer for that."

3. Omnicell Report
   7/17/02 3:46 a.m. 2 each Lorazepam 2 mg B , B
   7/17/02 4:03 a.m. 1 each Morphine 4 mg B , B
   withdrawn by Tawnia Iwasinski (orientee working with Nancy Dufault).
   7/17/02 4:26 a.m. 2 each Lorazepam 2mg B B
   7/17/02 4:26 a.m. 1 each Morphine 4 mg B , B
   withdrawn by Nancy Dufault.

Issue: Medication administration record shows documentation of medications by Tawnia Iwasinski. No documentation of medications withdrawn by Nancy Dufault.
Response: Nancy states, "I guess I didn't chart it....bad documentation on my part."

4. Omnicell Report
   6/21/02 2:25 a.m. 3 each Lorazepam 2 mg R , P
   6/21/02 2:26 a.m. 3 each Lorazepam 2 mg R , P
   6/21/02 2:27 a.m. 3 each Lorazepam 2 mg R , P
   Total of 18 mg Lorazepam withdrawn in 3 minutes by Nancy Dufault.

   IV administration record 6/ 20/02 and 6/21/02 shows:
   Lorazepam (no dose noted) administered 2000 (8 p.m.)
   Lorazepam (no dose noted) administered 0001 (12:01 a.m.)
   Lorazepam (no dose noted) administered 0430 (4:30 a.m.)

Issue: How could Lorazepam have been administered to the patient at 8 p.m. and 12 Midnight if it was not removed until 2:30 a.m.?
Response: Nancy – "I bolused through the IV drip...used '999' to bolus at 8, 12 and 4:30...then used the 18mg to replace the IV".

5. Omnicell Report
   5/21/02 8:09 p.m. 1 each Lorazepam 2 mg G , M
   5/22/02 11:42 p.m. 1 each Lorazepam 2 mg G , M
   5/23/02 9:53 p.m. 1 each Lorazepam 2 mg G , M
   5/29/02 11:26 p.m. 1 each Lorazepam 2 mg G , M
   5/30/02 11:25 p.m. 1 each Lorazepam 2 mg G , M

Issue: Order was for 1 mg. Wasted Lorazepam not witnessed by second RN in all cases.
Response: Nancy, "I guess I need to get better about checking my 'waste'."

Mary Brown RN
Mary Brown, RN
Director of Medical/Surgical Nursing

Jean D'Espinosa RN
Jean D'Espinosa, RN
Nurse Manager ICU/CCU/IMC

Rose Garvey Room
Present: Mary Brown, Jean D'Espinosa, Nancy Dufault, Dave Powers and Anne Marie Smith.

Conversation began at 11:00 a.m. on August 29th.

Mary Brown: "We received several scenarios and found discrepancies between the Omnicell and the MAR". "We discussed these with you and identified different types. From that meeting some remain unclear."

Scenario # 1:
Mary Brown: "The one I presented that was most concerning was regarding P R. In this case you took Ativan out of the omnicell at 2:25 a.m., 2:26 a.m. and 2:27 a.m. Each time you took out three (3) amps of 2 mg each totaling 18 mg within 2 minutes. You charted these drugs at 8p.m., 12 a.m., and 4 a.m. Do you remember?

Nancy Dufault: "Yes I remember."

Mary Brown: "You went on to tell us this was possible because what you had done was given 6 mg boluses through the IV drip of Ativan that was infusing at the documented times. You then went to Omnicell @ 2:25 a.m. to retrieve the Ativan so you could return the drug to the IV bag that was infusing. Is this right?"

Nancy Dufault: "Absolutely, that is what I said. I specifically remember that night and doing that."

Mary Brown: "Well the problem is this cannot be true. The Ativan drip had been discontinued that morning; there was no drip when you came on."

Nancy Dufault: After much thought – "I have no answer, I cannot recall that", "I really think that is what I did."

Scenario #2:
Mary Brown: "Another incident is regarding Morphine – where you removed it later and charted it earlier.

1. On May 4, 2002 – R V
   "You removed 4 morphine @ 6:20 a.m. and the documentation shows you gave it at 2:00 a.m. There is no other morphine removed for that patient that can account for it."

2. On May 7th – R V
   "You took out 4 mg of morphine at 1:14 a.m. per omnicell reports. You then charted the dose at 12:02 a.m."
   "Again, same patient – you took out morphine 4 mg:
   a. at 3:23 a.m. and documented it @ 2:00 a.m
   b. at 4:39 a.m. and documented it @ 4:00 a.m.

Mary Brown: "Numerous times this occurs where the documentation is earlier than the drug was removed from omnicell. You are also not documenting the dose you give."

Nancy Dufault: "Those times I charted it later; I just probably charted it wrong on SMS."

Scenario #3:
Mary Brown: The following are all on Isgro. You took out on May 14th the following:

1. 11:41 p.m. – 2 mg morphine – not charted at all.
2. 1:39 a.m. – 4 mg morphine – not charted at all.
3. 1:46 a.m. – 10 mg morphine – not charted at all.

"The question is why did you take out so much morphine and not chart them. Also, this patient did not even have this amount order."

Nancy Dufault: "Well, I cannot explain this – my documentation must be off – I'll get better."

Mary Brown: "Nancy, it is more than documentation, we have listed quite a variety of discrepancies which you do not have an answer for."

Jean D'Espinosa, RN
Nurse Manager ICU/CCU/IMC

JD/am